Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Buprenorphine/naloxone for opioid dependence: clinical practice guideline.

Bibliographic Source(s)

Handford C, Kahan M, Srivastava A, Cirone S, Sanghera S, Palda V, Lester MD, Janecek E, Franklyn M, Cord M, Selby P, Ordean A. Buprenorphine/naloxone for opioid dependence: clinical practice guideline. Toronto (ON): Centre for Addiction and Mental Health (CAMH); 2011. 145 p. [143 references]

Guideline Status

This is the current release of the guideline.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Levels of evidence (I, II-1, II-2, II-3, III) and grades of recommendation (A-E, I) are defined at the end of the "Major Recommendations" field.

Selecting Buprenorphine/Naloxone Maintenance Therapy

1. Once a patient is diagnosed with opioid dependence and is deemed appropriate for opioid agonist treatment, prescribers are encouraged to consider prescribing either buprenorphine/naloxone or methadone in order to increase retention in treatment and decrease opioid misuse.

(Level I, Grade A)

Clinical Assessment

2. Buprenorphine/naloxone maintenance treatment can be prescribed to patients in either a primary care setting or in a specialized addiction treatment setting. (Level I, Grade A)
3. Prior to initiating maintenance opioid agonist treatment the patient should meet the diagnostic criteria for opioid dependence. (Level III, Grade A)
4. The decision to initiate opioid agonist therapy with either buprenorphine/naloxone or methadone maintenance should be guided by the individual clinical circumstances and the patient's preferences. (Level III, Grade I)

Initiation, Maintenance, and Discontinuation of Buprenorphine/Naloxone Maintenance Treatment

5. A physician should have a structured approach, such as the one suggested in the clinical considerations (see section 3 of the original guideline document), to initiating buprenorphine/naloxone maintenance treatment in order to stabilize a patient at their maintenance dose as rapidly as possible while at the same time avoiding oversedation or precipitated withdrawal. (Level III, Grade A)
6. Prior to initiation of buprenorphine/naloxone treatment, the patient must provide informed consent and there must be physician documentation that the patient has been informed of the physical dependence on the medication and possible long-term nature of the maintenance treatment. (Level III, Grade A)
7. Once a stable maintenance dose is achieved, physicians can consider nondaily dosing of buprenorphine/naloxone as effective as daily dosing of buprenorphine/naloxone with respect to retention in treatment and reduction in illicit drug use. (Level I, Grade A)
8. When monitoring a patient on buprenorphine/naloxone maintenance, the physician should adopt a patient–centred urine drug testing strategy that maximizes clinical utility while avoiding testing without indication. (Level III, Grade I)
9. In making decisions regarding the provision of take-home doses of buprenorphine/naloxone, providers should use a clinical risk stratification strategy (as described in the clinical considerations) that aims to support patient autonomy while at the same time respecting patient and public safety. (Level III, Grade A)

Overdose, Mortality, and Other Adverse Effects

10. Policy makers should be aware that in countries where buprenorphine is equally available as methadone, buprenorphine has a lower attributable death rate than methadone. (Level II-3, Grade A)
11. Limited public funding is currently the major barrier to accessibility of buprenorphine/naloxone maintenance treatment in Ontario. The guideline authors recommend that policy makers remedy this barrier. (Level III, Grade B)
    Clinicians should be aware that there is little in the medical literature to guide them in terms of which opioid maintenance agent to prescribe an individual opioid-dependent patient. In making this decision, the prescriber and patient should consider the following, which is based on clinical experience.

12. Buprenorphine/naloxone may be preferred over methadone to treat opioid dependence in the following patient populations:
    a. When methadone is absolutely or relatively contraindicated, such as:
        i. Presence of, history of or increased risk of prolonged QT interval (Level I, Grade A)
        ii. History of methadone allergy (Level III, Grade A)
    b. History of significant side effects on methadone such as:
        i. Sexual side effects on methadone (Level II-2, Grade B)
        ii. Severe sedation or constipation with methadone (Level III, Grade C)
    c. Increased risk of toxicity from a full mu agonist:
        i. If suspect a lower tolerance to opioids (Level III, Grade B)
        ii. If concurrent heavy or unstable use of sedating drugs/medication (Level II-3, Grade B)
        iii. If elderly (Level III, Grade B)
        iv. If significant respiratory illness (Level III, Grade B)
    d. Good prognostic factors:
        i. Briefer history (i.e., less than one year) of opioid misuse (Level III, Grade C)
        ii. Social supports (Level III, Grade C)
        iii. Adolescents and young adults (Level III, Grade B)
    e. Past history of successful stabilization with buprenorphine/naloxone (Level III, Grade I)
    f. Patient choice and access. In particular patients residing in geographic areas where methadone is not available in a timely manner, or when challenging pharmacy access makes the possibility of alternate day dosing of buprenorphine/naloxone desirable. (Level III, Grade B)

13. Methadone may be preferred over buprenorphine/naloxone in the following patient populations:
    a. Pregnancy (specifically avoiding the naloxone component in the buprenorphine/naloxone combination product) (Level III, Grade A)
    b. Clinical situations where opioid withdrawal during induction is particularly hazardous – i.e., cardiovascular instability (Level III, Grade B)
    c. Prior inability to stabilize on buprenorphine/naloxone maintenance treatment (Level III, Grade B)
    d. History of abusing buprenorphine/naloxone via injection (Level III, Grade A)
    e. Patient side effects with or allergy to buprenorphine/naloxone or to excipients including acesulfame (Level III, Grade A)
    f. Patients experiencing dry mouth of severity that would interfere with dissolution and absorption of sublingual buprenorphine/naloxone tablets (dry mouth may be due to side effects of concurrent medications, chemotherapy, or conditions causing dry mouth, e.g., Sjogren's syndrome) (Level III, Grade A)
    g. Past history of successful stabilization with methadone (Level III, Grade I)
    h. Patient choice and access, in particular patients with limited financial resources that make reliable long-term use of buprenorphine/naloxone uncertain (Level III, Grade B)

Definitions:

Levels of Evidence

I	Evidence from randomized, controlled trial(s)
II-1	Evidence from controlled trial(s) without randomization
II-2	Evidence from cohort or case-control analytic studies, preferably from more than one centre or research group
II-3	Evidence from comparisons between times or places with or without the intervention; dramatic results in uncontrolled experiments could be included here
III	Opinions of respected authorities, based on clinical experience; descriptive studies or reports of expert committees

Grades of Recommendation

A	There is good evidence to recommend the action.
B	There is fair evidence to recommend the action.
C	The existing evidence is conflicting and does not allow making a recommendation for or against the use of the action; however, other factors may influence decision-making.
D	There is fair evidence to recommend against the action.
E	There is good evidence to recommend against the action.
I	There is insufficient evidence (in quantity and/or quality) to make a recommendation; however, other factors may influence decision-making.

Adapted from Definitions of Levels of Evidence and Grades of Recommendations of the Canadian Task Force on Preventive Health Care. Available from the CMAJ Web site .

Clinical Algorithm(s)

The original guideline document includes a sample buprenorphine/naloxone induction algorithm.

Scope

Disease/Condition(s)

Opioid dependence

Guideline Category

Counseling

Evaluation

Management

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Pediatrics

Pharmacology

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Nurses

Pharmacists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Substance Use Disorders Treatment Providers

Guideline Objective(s)

- To provide clinical recommendations for the initiation, maintenance, and discontinuation of ambulatory buprenorphine/naloxone maintenance treatment
- To contribute to education of practitioners regarding opioid prescribing, improved patient access to treatment for opioid dependence, and safe prescribing and dispensing of buprenorphine/naloxone

Target Population

Adults and adolescents with opioid dependence in Ontario, Canada

Interventions and Practices Considered

1. Ensuring that patient meets criteria for opioid dependence
2. Selecting either buprenorphine/naloxone or methadone maintenance therapy based on clinical assessment and patient preference
3. Use of a structured approach to initiate maintenance therapy
4. Obtaining and documenting informed consent
5. Monitoring therapy, including urine drug testing
6. Using a clinical risk stratification strategy in making decisions regarding the provision of take-home doses of buprenorphine/naloxone
7. Consideration of patient history, adverse effects, and contraindications when selecting either buprenorphine/naloxone or methadone maintenance therapy

Major Outcomes Considered

- Morbidity and mortality
- Quality of life
- Reduced sexual risk taking and illicit drug use
- Treatment retention and adherence
- Level of opioid/substance use
- Global harm reduction (e.g., criminal activity)
- Reliability of diagnostic tests
- Effectiveness of treatment
- Safety of treatment
- Adverse effects of treatment
- Cost-effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Identifying and Evaluating the Evidence

The Committee first met in late 2008 to discuss the overall scope of the guideline and to generate key clinical questions that they felt to be appropriate to try to answer in the guideline. Shortly thereafter, an analytic framework was developed and four important areas of key clinical questions were identified (see Appendix D in the original guideline document). The key clinical questions were used to inform the search for evidence, and the literature searches were conducted by an information specialist with the Guidelines Advisory Committee.

Identification and Selection of Studies

Search strategies were developed that addressed each key clinical question. Systematic searches were conducted of Medline, EMBASE, PsycLit, and the Cochrane Library for English language literature published between 1980 and 2009. Searches were conducted in January and February 2009. The full search strategy is available in Appendix B of the original guideline document. When existing good quality systematic reviews that addressed one or more of the key clinical questions were identified, the searches were limited to the time frame subsequent to the search used in those reviews. For efficacy studies, only randomized controlled trials and quasi-randomized controlled trials were included for consideration. For other key questions all study designs with a comparison group were considered. For adverse event and mortality outcomes, studies without a comparison group were also considered. Two independent reviewers examined 838 abstracts for possible inclusion. They ultimately reviewed 341 articles in full text (see Appendix E of the original guideline document for list).

Number of Source Documents

341 articles were reviewed in full text.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

I	Evidence from randomized, controlled trial(s)
II-1	Evidence from controlled trial(s) without randomization
II-2	Evidence from cohort or case-control analytic studies, preferably from more than one centre or research group
II-3	Evidence from comparisons between times or places with or without the intervention; dramatic results in uncontrolled experiments could be included here
III	Opinions of respected authorities, based on clinical experience; descriptive studies or reports of expert committees

Adapted from Definitions of Levels of Evidence and Grades of Recommendations of the Canadian Task Force on Preventive Health Care. Available from the CMAJ Web site .

Methods Used to Analyze the Evidence

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Two committee members were assigned to independently review each full text article and abstract data. The data were abstracted to evidence tables that described the characteristics of the studies and pertinent clinical outcomes, and the tables were distributed to the committee members for review prior to meetings.

Information captured in the data tables included study design, description of the intervention, number of study participants (where applicable), primary outcome measures, primary outcome results, secondary outcome measures, secondary outcome results, and any additional comments. Complete evidence tables will be available on request.

Recognizing that the two patient groups can be quite different, the committee attempted to distinguish studies of injection-heroin users versus other types of opioid-dependent patients, in particular those abusing prescribed oral opioids. Effort was also made to distinguish between studies that used buprenorphine mono-product as opposed to the buprenorphine/naloxone agent. Studies using buprenorphine/naloxone have only relatively recently appeared in the literature. As a result, most of the studies used and referred to in this guideline involve the use of buprenorphine mono-product. With the exception of the issue of buprenorphine diversion (see "Overdose, Mortality, and other Adverse Effects" in the "Major Recommendations" field and in Section 4 of the original guideline document), the authors felt comfortable using studies of the buprenorphine mono-product to inform this guideline. In fact, studies have been done that demonstrated similar outcomes when comparing buprenorphine mono-product to buprenorphine/naloxone. Where possible, the committee also distinguished between studies that employed a sublingual buprenorphine tincture as opposed to the commercially available sublingual tablet, since it has been demonstrated that the absorption can differ between the two delivery forms and that the bioavailability of the tablet is approximately 70 per cent of that of the oral solution.

The levels of evidence for recommendations were adapted from the Canadian Task Force on Preventative Health Care. The levels of evidence

describe the methodological rigour of the study.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Guideline Committee Membership

The Guidelines Advisory Committee of the Centre for Effective Practice facilitated the guideline development process, and a methodologist was present at committee meetings to ensure methodological rigour. Committee members were selected with the goal of achieving geographical and stakeholder representation, content expertise and breadth of practice type, and included specialists in the field of addiction medicine, family medicine, and pharmacy.

Recommendation Development and Approval

The committee developed recommendations based on the best available evidence. Certain aspects of the guideline have been informed by a reasonable amount of good quality evidence. Other aspects were crafted exclusively by committee consensus due to a lack of informative evidence. If evidence for buprenorphine was lacking for a particular clinical question and the committee was aware of related evidence regarding methadone, then the methadone-related evidence was eligible for consideration in formulating a final recommendation. Each recommendation is explicitly linked to the supporting evidence. It has also been noted if the evidence was insufficient for a particular recommendation.

The grading of recommendations was adapted from the Canadian Task Force on Preventative Health. The grades of recommendation comprise the level of evidence and clinical expertise. Areas of disagreement regarding recommendation phrasing or grade of recommendation were resolved through verbal consensus during the meeting or subsequent email correspondence. All recommendations were ultimately voted upon by all committee members.

Limitations

In writing these guidelines, the authors endeavoured to use evidence from systematic reviews driven by key clinical questions. However, there was an absence of specific guidance from the literature for many of the questions. Much of the guidance in the original guideline document, in particular in the Clinical Considerations sections, is largely based on expert opinion. It was felt that in areas where the literature was relatively silent it was important to fill in the gaps with expert opinion to ensure a logical sequence.

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation

A	There is good evidence to recommend the action.
B	There is fair evidence to recommend the action.
C	The existing evidence is conflicting and does not allow making a recommendation for or against the use of the action; however, other factors may influence decision-making.
D	There is fair evidence to recommend against the action.
E	There is good evidence to recommend against the action.
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Adapted from Definitions of Levels of Evidence and Grades of Recommendations of the Canadian Task Force on Preventive Health Care. Available from the CMAJ Web site .

Cost Analysis

The guideline developers reviewed published cost analyses.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The guideline was circulated in May, 2011, for external review and comment by relevant experts and stakeholders as identified by the committee. The guideline was also reviewed by two clinician reviewers trained by the Guidelines Advisory Committee in the use of the Appraisal of Guidelines for Research and Evaluation (AGREE) Instrument, and by members of the Physicians of Ontario Collaborating for Knowledge Exchange and Transfer (POCKET) Network of family physicians (www.pocketdocs.ca). Reviewers evaluated the guideline using the AGREE II Instrument (www.agreetrust.org) and were also asked to provide feedback on the implementability of the formal recommendations. Lastly the guideline was sent to three senior Centre for Addiction and Mental Health (CAMH) Faculty members for their review and open-ended feedback on the guideline content. Feedback from the external reviewers was reviewed by the chair and the committee, and was incorporated into the guideline as necessary.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate use of buprenorphine/naloxone for opioid dependence, which may contribute to:

- Education of practitioners:
  - Helping address overprescribing of opioids
  - Helping physicians recognize and treat opioid dependence
- Improved patient access to treatment for opioid dependence by:
  - Improving physician comfort in prescribing buprenorphine/naloxone
  - Enabling the use of buprenorphine/naloxone in primary care settings, in particular remote regions without specialist care
  - Advocating for increased public funding for buprenorphine/naloxone
- Safe prescribing and dispensing of buprenorphine/naloxone:
  - Providing guidance for safe prescribing and dispensing
  - Reassuring prescribers and regulators with direction on how to employ the medication more safely

Potential Harms

- Risk of harm with buprenorphine does still exist, including the risk of injecting the drug, and so practitioners must be systematic and thorough in their approach to diagnosing opioid dependence, determining eligibility for buprenorphine/naloxone and inducting and maintaining patients on buprenorphine/naloxone maintenance therapy.
- Potential adverse effects are summarized in section 4 of the original guideline document. Potential adverse effects include:

- Adverse effects resulting from mu agonist effects, including respiratory depression, changes in oxygen saturation, and opioid agonist psychological effects
- Abuse of the treatment drug (including intravenous, intranasal, or parenteral abuse of buprenorphine)
- Risk of overdose and mortality from overdose
- Sexual side effects
- Cognitive side effects
- Drug-induced toxic hepatitis (this phenomenon has generally been described in people with pre-existing liver disease or who are abusing buprenorphine parenterally)
- Increase in liver enzymes (e.g., in hepatitis C positive patients receiving buprenorphine)
- See section 4 of the original guideline document for additional detail.

Contraindications

Contraindications

Contraindications to the initiation of buprenorphine/naloxone are:

- Allergy to buprenorphine/naloxone
- Pregnancy (for buprenorphine/naloxone combination product specifically)
- Severe liver dysfunction
- Acute severe respiratory distress
- Paralytic ileus
- Decreased level of consciousness
- Inability to provide informed consent
- Possibly elevated transaminases beyond 3–5 times the upper limit of normal

Qualifying Statements

Qualifying Statements

The original guideline publication makes every attempt to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering medical, psychological, social, financial, legal or other professional services. The contents of this publication are based on information available at the time of publication. However, in view of the possibility of human error or changes in medical science or relevant legislation, neither the authors, editors, publishers nor any other party who has been involved in the preparation of this publication warrant that the information is in every respect accurate or complete, and they are not responsible for any errors or omissions or for the results obtained from the use of such information. If expert assistance is needed, the services of a competent professional should be sought.

Recommendation Development and Approval

- Legal advice was sought with respect to the appropriateness of making recommendations that would be seen as contradicting Health Canada's restrictions on prescribing buprenorphine/naloxone as outlined within the Suboxone product monograph.
- Recommendations and other content within the guideline may be less applicable in certain situations or with certain groups of patients. As stated in the introduction, these guidelines are meant to support and not replace the clinical judgment of the clinician when dealing with an individual patient.

See the "Clarifications and Limitations" section in the original guideline document for more information.

Implementation of the Guideline

Descriptions of Implementation Strategies

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Clinical Algorithm

Resources

Staff Training/Competency Material

Tool Kits

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Handford C, Kahan M, Srivastava A, Cirone S, Sanghera S, Palda V, Lester MD, Janecek E, Franklyn M, Cord M, Selby P, Ordean A. Buprenorphine/naloxone for opioid dependence: clinical practice guideline. Toronto (ON): Centre for Addiction and Mental Health (CAMH); 2011. 145 p. [143 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2011

Guideline Developer(s)

Centre for Addiction and Mental Health - Hospital/Medical Center

Source(s) of Funding

The development of this guideline was funded by the Centre for Addiction and Mental Health (CAMH). The funding for this guideline involved financial compensation from internal funds at CAMH to the chair and committee members for time spent in meetings, reviewing articles and abstracting data. The work of the committee was not directly influenced by CAMH.

Guideline Committee

Guidelines Advisory Committee (GAC) of the Centre for Effective Practice

Composition of Group That Authored the Guideline

Principal Author: Curtis Handford MD CCFP MHSc, staff physician, Addictions Program, Centre for Addiction and Mental Health and Department of Family and Community Medicine, St. Michael's Hospital, Toronto, assistant professor, Department of Family and Community Medicine, University of Toronto

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Contributor: Alice Ordean MD, CCFP, MHSc

Financial Disclosures/Conflicts of Interest

Conflict of Interest

As this guideline is somewhat unique in that it addresses the clinical use of a single pharmaceutical product from a single Canadian manufacturer, the committee made it a priority to minimize any real or perceived bias in the guideline development process.

The committee chair was selected because of his expertise in both primary care and addiction medicine and lack of any potential conflicts of interest with the manufacturer of buprenorphine/naloxone.

All committee members were required to fill out a conflict-of-interest disclosure statement both at the beginning and at the end of the guideline development process. These statements were reviewed by the committee chair. Several committee members disclosed potential conflicts of interest with the former and/or current manufacturer of buprenorphine/naloxone. In order to determine a strategy of managing potential conflict of interest in developing the guideline, the chair, with support from the guideline committee members, consulted very early in the process with the chief of staff at the Centre for Addiction and Mental Health (CAMH) as well as a CAMH bioethicist. The bioethicist offered several suggestions to the

chair for managing any potential conflicts of interest and thus minimizing bias in the development of the guideline.

The chair ultimately decided that all committee members would continue to participate fully on the committee, as their clinical expertise was extremely valuable to the process, but that the chair would be the sole principal author of the guideline and that fewer than 50 per cent of co-authors would have a declared potential conflict with the manufacturer of buprenorphine/naloxone. During the initial meeting of the committee, the chair was also given the authority to make the final decision about a particular recommendation if the committee was not able to achieve unanimity. Therefore, in the event that a dispute arose about a particular recommendation and consensus was not achievable, the chair was able to consider each committee member's potential conflict of interest in deciding on a final recommendation.

The CAMH bioethicist was also able to assist the committee chair in determining that CAMH did not have an institutional conflict of interest with Schering-Plough, the manufacturer of Suboxone at the time the guideline work began.

Specific Author Potential Conflict-of-Interest Disclosure Statements

All authors were invited to invoice CAMH for payment of honoraria related to the time they worked on the guidelines.

Dr. Handford received honoraria from Pfizer Inc. in 2006 for educational presentations; Dr. Kahan received honorarium from Schering-Plough for reviewing an online course, received paid expert testimony from Schering-Plough for a presentation to Health Canada regarding the buprenorphine/naloxone notice of compliance, received reimbursement for travel expenses to NIHB from Reckitt Benckiser and was paid by Reckitt Benckiser for attendance at a physician advisory board meeting; Dr. Srivastava received an honorarium from Schering-Plough for sitting on its Suboxone National Advisory Board and for developing educational program content, received an educational grant from Schering-Plough and received a paid consultancy from Reckitt Benckiser; Dr. Cirone declared no conflict; Ms. Sanghera declared no conflict; Dr. Palda declared no conflict; Dr. Lester declared no conflict; Ms. Janacek received an honorarium to develop and review educational material; Dr. Franklyn received honoraria from Reckitt Benckiser for attending an advisory board meeting and speaking at a conference; Dr. Cord received paid consultancies from the Nova Scotia Chronic Pain Collaborative Care Network, the College of Physicians and Surgeons of Ontario, and CAMH, he received payment for the development of educational presentations from the Ontario College of Family Physicians, the General Practitioner Psychotherapy Association, and the Toronto Psychoanalytic Society, and he received Advisory Board payments from Purdue Pharma Canada; Dr. Selby received grants and research support from Health Canada, Smoke-Free Ontario, MHP, CTCRI, CIHR, Alberta Health Services (formerly Alberta Cancer Board), Vancouver Coastal Authority, Pfizer, OLA, ECHO, NIDA, and CCS, he received Speakers Bureau honoraria from Schering Canada, Johnson & Johnson Consumer Health Care Canada, Pfizer Inc. Canada, Pfizer Global, Sanofi-Synthelabo Canada, GSK Canada, Genpharm and Prempharm Canada, and NABI Pharmaceuticals, and he received consulting fees from Schering Canada, Johnson & Johnson Consumer Health Care Canada, Pfizer Inc. Canada, Pfizer Global, Sanofi-Synthelabo Canada, GSK Canada, Genpharm and Prempharm Canada, NABI Pharmaceuticals, V-CC Systems Inc., and EHealth Behaviour Change Software Co. AstraZeneca Canada Inc.

Guideline Endorser(s)

College of Family Physicians of Canada - Professional Association

Guideline Status

This is the current release of the guideline.

Guideline Availability

Available from the Portico Web site .

Availability of Companion Documents

The following is available:

- Opioid addiction. [internet]. Toronto (CA): Centre for Addiction and Mental Health; 2012. Available from the Centre for Addiction and Mental Health Web site .

In addition, the appendices of the original guideline document provide information on buprenorphine/naloxone availability

in Canada and buprenorphine training courses, a sample buprenorphine/naloxone treatment agreement, and the Clinical Opiate Withdrawal Scale (COWS).

The supplements to the original guideline document provide the following additional clinical information to assist the user in adopting the guidelines: key concepts in addiction; pharmacology of buprenorphine; clinical assessment prior to buprenorphine/naloxone therapy; ordering and interpreting urine drug tests; buprenorphine/naloxone dispensing; concurrent disorders; buprenorphine/naloxone prescribing for adolescents and young adults; buprenorphine use in pregnancy; buprenorphine maintenance therapy and human immunodeficiency virus (HIV), hepatitis infection; and acute and chronic pain in buprenorphine/naloxone maintenance.

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on March 13, 2013. The information was verified by the guideline developer on April 29, 2013. This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on Opioid pain medicines.

Copyright Statement

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